VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 27, 2011

Mary Naumann, Administrator
Willows Of Windsor
121 State Street
Windsor, VT 05089

Provider #:0044

Dear Ms. Naumann:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 7, 2011** .

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____ RECEIVED Division of JUL 18 11 Licensing and Protection	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site licensing survey and complaint investigation was completed from 4/6/11 to 4/7/11 by the Division of Licensing and Protection. No deficiencies were cited related to the complaint investigation, the following are the results of the licensing survey.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not maintain a current care plan for 1 of 3 applicable residents (Resident #1). Findings include: 1) Per record review on 4/7/11, Resident #1 had documentation of a fall on 1-24-11 and also of near falls from crawling out of bed during the night and is now sleeping in a recliner in his room. The care plan did not address the specific fall risk interventions to prevent or minimize the likelihood of falls related to crawling out of bed nor the care needs related to sleeping in the recliner. This was confirmed with the manager on 4/7/2011.	R145	CLIENTS CARE PLAN WAS UPDATED TO INDICATE PREFERENCE FOR SLEEPING IN HIS RECLINER 5/2011 I ADDED FALL RISK INTERVENTIONS SPECIFIC TO HIS NEEDS. WE WILL ASSURE CARE PLANS ARE UPDATED AS PART OF OUR WEEKLY RESIDENT MANAGEMENT MTG. —R145 POC Accepted 7/26/11 PMcotaRN	
R168 SS=D	V. RESIDENT CARE AND HOME SERVICES	R168		

Division of Licensing and Protection

Mary Naumann RN TITLE 7-10-2011 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R168	Continued From page 1 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on record review and interview with manager, the nurse failed to assure that staff administering insulin had completed their delegation training and that a return demonstration of insulin administration to a resident has been observed by the nurse. Findings include: 1) Per record review and interview on 4/7/2011, a training was offered on 3/1/11 on Insulin and Diabetic Care. There was no documentation on who attended the training nor any documentation	R168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R168	Continued From page 2 to indicate that delegated staff were observed by a nurse doing a return demonstration of insulin administration. This was confirmed with the manger on 4/7/2011.	R168	THE RN PROVIDED REPEAT DIABETIC & INSULIN INSERVICE & PARTICIPATION WAS DOCUMENTED ALL INSERVICE RECORDS WILL BE KEPT IN A CENTRAL BINDER. RETURN DEMONSTRATION ON INSULIN USE WILL BE DOCUMENTED ON EACH PERSON'S TRAINING RECORDS.	5/2011
R174 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (2) Medications requiring refrigeration shall be stored in a separate, locked container impervious to water and air if kept in the same refrigerator used for storage of food. This REQUIREMENT is not met as evidenced by: Based on observations during the initial tour of the home on 4/6/2011 and confirmed through interview, the home failed to secure medication that was stored in the same refrigerator used for food storage. Findings include: 1) On the morning on 4/6/2011, during the initial tour of the home, three vials of Novolog insulin were found stored unsecured in the refrigerator that was used for food storage. This was confirmed with a staff member during initial tour and also with home manager on 4/6/2011.	R174	-R168 POC Accepted 7/26/11 PMcotaRN A LOCKED REFRIGERATOR BOX WAS ALREADY AVAILABLE & IN USE FOR THIS PURPOSE. I HAVE REITERATED TO STAFF THAT ITS USE IS MANDATORY. MANAGEMENT NOW CHECKS & DOCUMENTS WEEKLY FOR COMPLIANCE.	7/2011
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and	R179	-R174 POC Accepted 7/26/11 PMcotaRN	5/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 3 techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not *limited* to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that all employees providing direct care to residents completed the required annual training's. Findings include: 1) Per record review on 4/6/11, 1 of 5 direct care providers did not have documentation to demonstrate receiving training in the required areas.	R179	THIS EMPLOYEE HAS UPDATED HER TRAINING. A MANAGER CONFIRMS & DOCUMENTS QTRLY TO ASSURE COMPLIANCE -R179 POC Accepted 7/26/11 PMcGuirk	6/2011
R181 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a	R181		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R181	Continued From page 4 person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that 5 of 5 current employees passed the abuse registry and criminal background checks. Findings Include: 1) Per record review done on 4/7/11, 5 of 5 current employees had no evidence in their employee records of an abuse registry check. This was confirmed by the Manager on 4/7/11. 2) Per record review on 4/7/11, 5 of 5 current employees had no evidence in their employee records that a criminal background check was done. This was confirmed by the Manager on 4/7/11.	R181	WE HAVE PLACED A FOLDER OF BACKGROUND CHECKS MISSING DOCUMENTATION WILL BE IN PLACE NLT 7/2011 ALL MANAGERS WILL BE AWARE OF WHERE THESE RECORDS ARE STORED. - R181 POC Accepted 7/26/11 PMcGarry	7/2011
R246 SS=D	VII. NUTRITION AND FOOD SERVICES	R246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R246	Continued From page 5 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/6/11, the facility failed to reject cans with dents. The findings include: 1) Per observation of the food storage area on 4/6/11, accompanied by a staff member, two cans of food goods intended for consumption by the residents were severely dented. After discussion of the regulation, the staff member removed the dented cans from the shelf and moved them to another area.	R246	STAFF IS TO CHECK PANTRY ITEMS AND DISPOSE OF DENTED CANS A MANAGER SPOT CHECKS THIS WEEKLY (& DOCUMENTS) -R246 POC Accepted 7/26/11 PMcotaRN	8/2011
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to consistently monitor freezer	R247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 6 temperatures to assure perishable foods were stored at safe temperatures. Findings include: 1) During observations of the kitchen and storage areas on 4/6/11, there were no thermometers in 4 freezers. This was confirmed by charge staff member on 4/6/11.	R247	ALL REFRIGERATORS & FREEZER COMPARTMENTS HAVE THERMOMETERS A MANAGER CHECKS THIS WEEKLY & RECORDS THAT THEY HAVE BEEN CHECKED -R247 POC Accepted 7/26/11 AMcotaRN	5/2011
R291 SS=E	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that water temperatures did not exceed 120 degrees Fahrenheit. Findings include: 1. Per observation on 4/7/11, the water temperature in a resident bathroom in the basement was identified at 134 degrees Fahrenheit and a resident bathroom on the 1st floor was identified at 132 degrees Fahrenheit. Immediately following these readings, the Manger of the home confirmed that the hot water tank thermostat was set at 135 degrees Fahrenheit which she immediately turned down.. The manager confirmed that water temperatures did exceed 120 degrees Fahrenheit and that there was no system in place to monitor temperatures on a regular basis.	R291	WE ARE CHECKING & DOCUMENTING TEMPERATURES WEEKLY TO ASSURE COMPLIANCE. -R291 POC Accepted 7/26/11 AMcotaRN	4/2011
R302 SS=E	IX. PHYSICAL PLANT	R302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING _____ B. WING _____	C 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R302	Continued From page 7 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through interview with the home's manager, the home failed to conduct the required number of fire drills and did not rotate times of day. Findings include: 1) Per record review of the home's fire drill long on 4/7/11, fire drills were not recorded as being done 6 times a year as required and did not include any night time drills. This was confirmed with the manager on 4/7/11.	R302	WE ARE NOW FOLLOWING THE HIGHER STANDARD OF 6 DRILLS/YR. A NIGHT DRILL WILL BE DONE ANNUALLY. COMPLIANCE IS MONITORED/ DOCUMENTED MONTHLY TO ASSURE COMPLIANCE. -R302 POC Accepted 7/26/11 AMcotuRN * Please note: 2 night shift fire drills are required annually.	